TESTIMONY

OF THE

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS'

SPECIAL COMMITTEE ON HEALTH INSURANCE

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE COMMERCE COMMITTEE

OF THE UNITED STATES HOUSE OF REPRESENTATIVES

ON

MEDICARE PROVIDER SERVICE NETWORKS

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INTRODUCTION

Good Morning Mr. Chairman and Members of the Subcommittee. My name is Josephine Musser. I am President of the National Association of Insurance Commissioners (NAIC) and Chair of the NAIC's (EX) Special Committee on Health Insurance. I am also Commissioner of Insurance for the State of Wisconsin. With me is David Randall, Deputy Director of the Ohio Department of Insurance and Vice Chair of the NAIC's Regulatory Framework Task Force. Together we are going to speak to you today about the regulation of provider-sponsored health insuring organizations participating in the Medicare managed care program.

The NAIC, founded in 1871, is the nation's oldest association of state public officials and is composed of the chief insurance regulators of the fifty states, the District of Columbia, and four U.S. territories. The NAIC's (EX) Special Committee on Health Insurance is composed of 42 of our members. The NAIC established this Special Committee over three years ago as a forum to discuss federal proposals related to health insurance reform and to provide technical advice on a nonpartisan basis to all who sought our expertise. On behalf of the NAIC Committee, we would like to thank you for the opportunity to discuss with you issues related to the regulation of health insuring organizations sponsored by providers.

The states have traditionally regulated the business of insurance. This traditional role was affirmed by Congress in 1945 when Congress passed the McCarran-Ferguson Act.[1] We believe that all health insuring organizations, whether they are sponsored by providers or others, ought to continue to be regulated by the states. States welcome the expressions by members of Congress in support of the states. In the case of insurance regulation, we urge Congress not to dilute the states' authority to regulate insurance by treating provider organizations specially in federal legislation.

We would like to state at the outset that, based on our experience in state insurance regulation, we do not view health insuring organizations sponsored by providers as substantively different from other health insuring organizations. Health insuring organizations, with varying forms of ownership and affiliations, are licensed by the several states. These organizations are required to obtain a state insurance license because of the insurance function they perform. Organizations subject to state insurance regulation include organizations that are sponsored by providers. The NAIC Committee submits that any federal proposal that would regulate provider organizations differently from other health insuring organizations first needs to demonstrate that structural differences merit different regulatory treatment. We do not believe that any such showing has been made.

Health insuring organizations contract with individuals, employers, or other groups to receive a prepayment in exchange for covering the cost of an unknown, future level of health care services. In doing so, the health insuring organization assumes what is commonly known as insurance or actuarial risk. Under this arrangement, the individual, employer, or other group transfers to the health insuring organization some or all of their own risk

of financial loss as a result of the use of health care services. Because the actual level of services that will be used is unknown, the health insuring organization is at risk for financial loss if the amount of services used exceeds the amount of the prepayment (commonly known as a premium). The principal characteristic of a health insurance arrangement is not only the transfer of the risk of financial loss to the health insuring organization. The health insuring organization also spreads the risk of financial losses associated with the use of health care services by any one individual among a group of individuals insured by the organization. Organizations that assume insurance risk on behalf of an individual, employer, or other groups, such as the Medicare program, are engaged in the business of insurance and should be subject to state insurance regulation.

In addition to insurance risk, all health insuring organizations must deal with several other forms of risk, including asset risk and general business risk. All health insuring organizations face asset risk; the risk that existing assets will decline in value and erode surplus as a result of that decline. Additionally, all health insuring organizations face general business risks; the range of risks associated with any other type of business such as assessments, administrative expense overruns, and environmental changes. To a large extent, the different risks health insuring organizations face are interrelated. For example, losses associated with insurance risk affect the ability of a health insuring organization to meet the many demands associated with general business risk.

Examples of Principal Types of Risk for Health Insuring Organizations

- ***Insurance or Actuarial Risk***
- ***Asset Risk***
- ***General Business Risk***

State insurance departments regulate health insuring organizations through a host of fundamental consumer protection activities. Insurance departments license organizations engaged in the business of insurance. The licensing standards include financial requirements that the organization must meet. The departments conduct extensive examinations of licensed organizations to review their financial condition and market conduct activities. State insurance departments supervise, rehabilitate, or liquidate financially distressed or insolvent organizations. Also of importance, state insurance departments handle complaints and inquiries from the general public. The departments also regulate agents and others that serve insurance organizations.

Health maintenance organizations (HMOs) and competitive medical plans (CMPs) participating in

the Medicare managed care program must comply with state licensure standards in addition to federal standards. The federal standards build upon, rather than preempt, fundamental state requirements. Importantly, all health insuring organizations serving the Medicare managed care program are regulated in a consistent, level fashion. State insurance regulation serves as the foundation for the current regulatory structure. It provides fundamental protections that extend beyond financial solvency and other licensing standards to market conduct standards as well as financial examination activities. These fundamental consumer protections are essential because of the public policy concerns inherent in the health insurance function. To provide these consumer protections itself, the federal government would need to replicate the states' insurance regulatory framework. Doing so would result in significant and unnecessary costs to the federal government.

The appropriate manner of regulating provider-sponsored health insuring organizations that serve the Medicare managed care program is an important question for several reasons. First, many providers lack experience in assuming insurance risk. Second, the population served by the Medicare program, the elderly and disabled, tend to use more health care resources than other individuals. And third, some providers face complex incentives in today's competitive health care environment. For example, hospitals face added pressures in a managed care market. They have to balance the challenge of managing care cost-efficiently with the challenge of filling their beds

and increasing hospital market share.[2] These challenges may make it more difficult for them to operate within the limited payment available under an insurance arrangement. Each of these factors argue for effective regulatory oversight.

Organizations that are sponsored by providers participate and make important contributions to the health insurance market. However, states believe strongly that all health insuring organizations that perform similar functions should be subject to similar regulatory standards. States have developed their regulatory standards through long-standing experience. Particularly in today's intensely competitive health insurance environment, where the risk and magnitude of insolvency can be significant, states are a necessary component to any regulatory structure for health insuring organizations participating in a federal program.

CHARACTERISTICS OF HEALTH INSURING ORGANIZATIONS

Types of Health Insuring Organizations

In the health insurance context, there are a number of types of health insuring organizations that are regulated by state insurance departments. This section reviews the types of health insuring organizations regulated by the states and the insurance functions they perform.

State-regulated health insuring organizations include:

- traditional indemnity insurance carriers;
- Blue Cross and Blue Shield plans;

x
- health maintenance organizations; and,

x
- limited health service organizations.

Under a traditional indemnity insurance contract, the health insuring organization takes on the risk of loss associated with a medical condition. The risk is assumed in exchange for a prepayment by an individual, employer, or other group. Through this indemnity contract, the insurer may promise to pay an individual who has already paid for the medical care received; this is the traditional approach for indemnity insurance carriers. Or, the insurer may promise to pay the provider for medical care received by the subscriber; this is the traditional approach for Blue Cross and Blue Shield plans. In other words, the traditional indemnity insurance carrier and the traditional Blue Cross and Blue Shield plan pays the individual or the provider for the medical services that are received. The traditional indemnity insurance carrier or traditional Blue Cross and Blue Shield plan does not actually deliver, or contract for the delivery of, those medical services.

Health maintenance organizations (HMOs) are health insuring organizations that manage care and serve both an insurance and delivery function. HMOs may be freestanding or subsidiaries of an indemnity insurance carrier or Blue Cross and Blue Shield plan. In consideration for a prepayment by an individual, employer, or other group, HMOs deliver or arrange for the delivery of health care

services. Like the traditional indemnity insurer and traditional Blue Cross and Blue Shield plan, the HMO is responsible for the cost of care. HMOs differ from traditional indemnity insurance carriers and traditional Blue Cross and Blue Shield plans in that HMOs are responsible for delivering or arranging for the delivery of that care as well. HMOs fulfill this responsibility by entering into contractual arrangements with providers or groups of providers, by providing the services directly themselves, or through some combination thereof. For example, if an individual is in need of a tonsillectomy, the HMO is not only responsible for covering the cost of the physician, hospital, and other services related to the tonsillectomy, but is also responsible for maintaining a network of available physicians, hospitals, and other health care resources to deliver the tonsillectomy.

Traditional indemnity insurance carriers may also offer services that do not involve insurance risk. These lines of businesses may include third party administrator services (TPA) or preferred provider organizations (PPOs) that do not bear insurance risk. In other words, under these arrangements, the health insuring organization is not spreading the financial risk of loss among a group of persons. Instead, it basically accepts a fee to perform administrative services, such as claims processing and marketing. Some HMOs also offer non-insurance risk TPA and PPO-type services where the HMOs "rent" the networks that they created and the renters of the network pay for health care services on a fee-for-service basis.

Limited Health Service Organizations (LHSOs) are organizations that deliver or arrange for the delivery of a limited range of health services on a prepaid basis. Examples of limited health services are dental care services, vision care services, mental health services, and pharmaceutical services.

An organization that is one of these types of health insuring organization — traditional indemnity insurance carrier, Blue Cross and Blue Shield plan, HMO, or LHSO — may or may not be sponsored by providers. As described in more detail later in this testimony, there are HMOs licensed in the states, including Wisconsin and Ohio, that are owned or controlled by providers. Under the current structure, state standards apply to organizations that perform similar functions and Medicare requirements do not undercut these requirements. Insurance regulation by ownership and acronym as opposed to by function would create an unnecessarily divided regulatory structure and severely undermine the ability to foster a competitive level playing field in the health insurance market. Further, we submit that such a split structure erodes the efficacy of state regulation of health insuring organizations.

Common Elements of Health Insuring Organizations

The activities of all health insuring organizations share the common elements of the insurance

function. The extent to which an entity is provider-sponsored does not impact the analysis regarding their function (and hence, the regulatory structure to which they should be subject). Consequently, the most appropriate approach to the regulation of health insuring organizations is by function and not by acronym. This section reviews the common elements of the arrangements entered into by health insuring organizations and distinguishes these arrangements from those which generally do not involve insurance.

Whether they are provider-sponsored or not, health insuring organizations — traditional indemnity insurers, Blue Cross and Blue Shield plans, HMOs, or LHSOs — have certain key elements in common. Health insuring organizations contract with an individual, employer, or other group. The purpose of the contract is to cover payment for a range of health care services which may be required in the future. The amount of the services that will actually be utilized is unknown. Health insuring organizations accept a prepayment from the individual, employer, or other group in exchange for assuming the financial risk associated with the cost of the health care services covered by the contract. Health insuring organizations pool all of the prepayments by the individual, employer, or other group of persons to cover the cost of health care services used. Health insuring organizations are at risk for financial loss if the cost of an individual's care is greater than anticipated and exceeds the prepayment made by or on behalf of the individual. All health insuring

organizations are involved in arrangements that contain these elements.

Common Elements of Health Insuring Organizations

a)

- ***Contracts with an individual, employer, or other group***
- ***Pays for or delivers a range of health care services***
- ***Pays for or delivers an amount of services that is unknown in advance***
- ***Accepts a prepayment for assuming the financial risk associated with health care services***
- ***Spreads the risk of loss among a group of persons by pooling the prepayments made by or on behalf of individual enrollees to cover the cost of services for all individuals in the group***
- ***Runs the risk of suffering financial loss if the cost of an individual's care is greater than anticipated.***

General rules exist to help distinguish between arrangements that have the common elements of an insurance arrangement and those that do not. A common factor among arrangements that generally do not involve insurance risk is that the payment method is linked to the actual use of predetermined and identifiable services to a specific enrollee. Consequently, the organization receiving the payment does not rely on payments for a pool of enrollees to fund care for specific individuals. The payment of a fee that is received to perform a specific service is a factor that distinguishes an insurance arrangement from one that is not an insurance risk arrangement. No payment is received for

services which are not used.

In contrast, health insurance arrangements are not directly tied to the actual use of specific services by an enrollee. In exchange for a prepayment, the health insuring organization agrees to pay for or deliver a range of services, regardless of the amount of services the enrollee actually uses. The health insuring organization is liable for expenses beyond the prepaid amount. If the enrollee uses fewer services than are covered by the prepayment, the health insuring organization keeps the remaining amount of the payment.

An arrangement involving a prepayment that is not tied directly to the actual use of specific services is insurance risk for two reasons. First, the health insuring organization bears the risk that the costs of any individual's use of services will exceed the amount of prepayment by that individual. Second, the health insuring organization pools the prepayments of all covered individuals. Consequently, the health insuring organization relies on the law of averages to ensure that any one individual's use of services will be balanced by the use (or lack of use) of other covered individuals.

Organizations that assume insurance risk through the receipt of a prepayment for an undetermined amount of services are engaged in the business of insurance and give rise to the public policy

concerns that insurance regulation is designed to address. Arrangements that involve the spreading of risk often rely upon complex, actuarial analysis involving the calculation of statistical risk for their financial success. In contrast, business risk arrangements, like those that involve the payment of a fee for a specific service, do not involve risk-spreading and do not inherently carry with them the same nature of risk as insurance risk. Additionally, prepayment for the future delivery of services in an insurance risk arrangement establishes a long-term commitment to the consumer. State insurance solvency and other standards provide fundamental protections to consumers against financial incentives inherent in health insurance arrangements. State standards also serve to strengthen the ability of participants in the health insurance market to fulfill their obligations to the consumer and other parties affected by the health insurance arrangement.

Provider organizations have argued that direct provision of services by providers transforms the financial risk of loss to a more general form of business risk rather than insurance risk. That is not the case. As long as pooling of financial risks of loss exists, insurance risk is present and they are subject to regulation by the states. Direct provision of services by providers will rarely reduce the insurance risk to a *de minimis* level. Many question the assertion that providers are willing to take reductions in their own salaries if the organization experiences significant losses. Nevertheless, even if providers are willing to work on greatly reduced or nonexistent additional income, the health

insuring organization still may be responsible for a wide range of expenses necessary to support the provision of health care services. In addition to the expenses of physician services, examples of additional expenses may include:

- Other Clinical Personnel (including nurses, nurse assistants, physical therapists, laboratory technicians, etc.)
- Administrative Staff (including business office managers, registration clerks, secretaries, etc.)
- General Administrative Expenses (including medical and paper supplies, patient registration, information systems, data and claims processing, etc.)
- General Facility Expenses (including electricity, lights, water, phone, etc.)
- Laboratory services
- Debt Service (including for facility, equipment, etc.)
- Other Business Expenses (including legal and actuarial services, etc.)

Further, health insuring organizations must deal with the general business risks associated with having adequate cash flow (commonly known as liquidity). This is a particularly important issue for organizations that are owned or controlled by providers. These organizations, which may be

nonprofit, may have inconsistent levels of cash flow available to meet expenses. Many of their assets are in buildings and equipment, which are unavailable if the organization needs additional funds to pay claims or cover general business expenses.

The ownership or control of the health insuring organization does not affect the type or magnitude of risk in an arrangement to any substantive degree. The type of risk being assumed by these organizations triggers the need for the application of fundamental state consumer protections. All organizations that perform the same or similar function, irrespective of the organization's acronym, should be subject to the same or similar standards when serving the Medicare program.

State Regulation of Health Insuring Organizations

Because of the public policy concerns present when an organization is engaged in the business of health insurance, health insuring organizations need careful oversight. States have developed significant expertise in providing this oversight as the primary regulators of insurance, which was underscored by Congress in the McCarran-Ferguson Act. The most fundamental components of state regulation include the licensing process, financial standards and examinations as well as market conduct standards and examinations. The process for the licensing of a health insuring organization

is a detailed process in Wisconsin, as it is in the other states. State regulation of HMOs can be used as an example to illustrate the states' regulatory process for health insuring organizations.

The regulation of HMOs is an apt example of the state regulatory process because most health insuring organizations currently operating in the marketplace that are sponsored by providers are licensed as HMOs. In Wisconsin, for example, most of the HMOs operating in Wisconsin were originally organized by sponsoring provider groups. The ownership status of these organizations has changed over time as the marketplace has consolidated. Wisconsin currently has sixteen (16) licensed HMOs that are provider-owned or controlled and two (2) indemnity insurers that are provider-owned or controlled.

A few examples may provide a sense of the various forms and structures of these provider-sponsored health insuring organizations. In Wisconsin, one of the licensed health insuring organizations is sponsored by a hospital and a clinic. Another licensed organization is wholly owned by an integrated delivery system. Yet another organization is owned one-third by an indemnity insurer, one-third by a hospital, and one-third by a clinic.

- Licensing

The first step in the regulatory process for an HMO is to submit to the state an application for a license (also called a certificate of authority). Organizations that perform the functions of an HMO without obtaining a license are subject to Wisconsin's unauthorized insurer statute. The application includes a variety of important materials such as the organization's articles of incorporation, bylaws, proposed detailed business plan, feasibility study, financial statements, and commitment of a viable provider network. The applicant must also meet minimum start-up capital requirements. Several staff members are usually necessary to review properly each individual application.

Once an application is received, the state will review the application to determine if all the information needed to perform a proper review is included. The state will also verify the information contained in the application. For example, the state will want to make certain that there is sufficient capital and surplus deposited in an acceptable financial institution.

In Wisconsin, the average application processing time is approximately 60 days. This number varies by state. The length of the application processing time is dependent upon a number of factors including the length of time it takes for an application to become complete, the number of applications under consideration at a particular time, and the number of staff available to review the

applications. Usually, the initial submission of the application is incomplete. The average application processing time for complete applications by most states is within ninety (90) days. For reference, the appendix of this testimony includes a list of state insurance department contacts for questions on individual state application processes. This list of state insurance department health contact persons can also be found on the NAIC's home page on the internet.

Source: NAIC

State Insurance Department Survey, February 1997.

The completeness of the application and the responsiveness of the applicant can greatly affect the length of the application process. The states have found that applicants who familiarize themselves with the application process prior to filling out an application receive final responses to their licenses

more quickly. State insurance departments recommend to applicants that they meet with the department prior to filling out an application to learn more about the application process, including the components of a successful application and the pitfalls to avoid. Departments also recommend that applicants maintain contact with the department while developing the application. Organizations that follow this approach tend to submit applications that are closer to completion, and consequently, tend to have applications that can be processed more quickly. Extended periods of time for application processing are often the result of inadequate information from the applicant or lack of timely response to department requests for information.

- Financial Standards and Examinations

Every state regulates HMOs as does the District of Columbia, American Samoa, and Puerto Rico. More than half of the states have HMO laws based upon the NAIC's Health Maintenance Organization Model Act (the "HMO model"). The HMO model governs persons that deliver or arrange for the delivery of basic health care services to enrollees on a prepaid basis. Under the HMO model, HMOs are subject to initial minimum net worth requirements of $1,500,000 and must maintain minimum net worth requirements of $1,000,000.[3] Contracts between the HMO and a contracting provider must contain a hold harmless provision that prevents the provider from holding

the subscriber or enrollee liable if the HMO does not pay the provider.

In Wisconsin, the initial minimum net worth requirements are $1.125 million. This $1.125 million must consist of $750,000 of capital and $375,000 of initial surplus. The capital requirements must be met through cash contributions by the HMO's sponsors and stockholders and not through such mechanisms as lines of credit, letters of credit, or subscription agreements.

HMOs must also maintain financial solvency and stability for the protection of HMO enrollees and the health insurance market. Wisconsin HMOs must maintain a minimum net worth of $750,000 or three (3) percent of the previous twelve (12) months' premium, whichever is greater. They must also maintain a security deposit equal to one (1) percent of the premium written by the HMO in the prior year. Further, as with any other insurance company doing business in Wisconsin, the HMO must undergo an annual CPA audit. Typical reinsurance practices for Wisconsin HMOs are to maintain $50,000 to $75,000 in reinsurance coverage. The Wisconsin Office of the Commissioner of Insurance examines the business plan submitted by the HMO to assess its approach and ensure that it is prudent.

In addition to the financial standards that a health insuring organization must meet, states perform financial examinations of health insuring organizations; this is one of the most important aspects of state insurance regulation. These financial examinations involve becoming familiar with the company's management and operations, holding meetings with the organization, and reviewing the books and records of the organization. The examination will include a review of audit operations and controls, budgeting and budget monitoring processes, and financial planning and reporting processes. Certain aspects of the organization may be targeted by the state based upon the research leading up to the actual examination or the course of the examination itself. If there are indications of financial problems, the examination will be more comprehensive

than otherwise.

One of the most important aspects of state regulation is the ability of the state to intervene in the event of financial problems. When the state becomes aware of a financial problem, it will conduct either informal or formal supervision activities which might include requesting a business plan for resolving problems or requiring a change in certain business practices to correct the problems. The state may also place the organization under its supervision until such time as the organization can perform appropriately the necessary functions without supervision. If all else fails, the state may liquidate the organization.

- Market Conduct Standards and Examinations

Further, the states establish market conduct standards which they monitor and enforce. Market conduct standards related, but not limited to, marketing, the issuing of policies, and claims handling must be met. For health insuring organizations, such as HMOs, standards related to quality assurance, grievance, provider credentialing, and other areas are also relevant.

States perform market conduct examinations to determine compliance with state market conduct standards. In a market conduct examination, the state insurance department initiates and conducts an extensive examination of a health insuring organization, including visits to the organization's offices, to determine how the company is conducting its business within the state. These examinations focus on such areas as an organization's marketing and sales, and its payment of claims and involve the review of numerous records and files.

According to one source, approximately 15-20 percent of the existing HMOs in this country are estimated to be organizations

sponsored by providers.[4] A recent NAIC survey of state insurance departments indicates that, of the 39 states which have responded to the survey thus far, at least 27 of them currently have licensed organizations that are owned or controlled by providers under their insurance laws. A number of states have applications pending or are in discussions with organizations that are owned or controlled by providers and that plan to file an application with the department. And, as will be discussed below some states have organizations that were owned or controlled by providers upon initial licensure but have experienced change in ownership or control since that time.

The vast majority of these organizations are licensed as HMOs. One example of a licensed HMO owned by providers in Ohio is U.S. Health HMO. U.S. Health HMO was formed by an organization composed of U.S. Health Corporation, a hospital-owned entity, and Medical Group of Ohio, an independent practice association. The premium paid to U.S. Health HMO, an entity recently licensed by the Ohio Department of Insurance, is distributed to pay administrative and marketing expenses, contracting providers, and profits to the provider owners.

The state of Texas reports that about one-half of the HMO licenses issued in the past two years have been to organizations sponsored by providers. Some examples of these organizations are hospital organizations such as, Texas Children's Hospital, Memorial Sisters of Charity, and Seton Health Systems, as well as physician organizations such as, Physicians Care HMO. In the state of Pennsylvania, several HMOs owned or controlled by providers serve both the urban and rural markets. One of these organizations, Geisinger Health Plan in Pennsylvania, which is currently composed of a medical center and physician group practice, is said to be the largest rural HMO in the country.

Several states, including some that currently do not have licensed organizations that are owned or controlled by providers, reported that some licensed organizations may have been initially formed by providers but are no longer owned or controlled

by providers due to mergers or management changes. Changes in ownership of an organization are not that unusual given the evolution and rapid consolidation in today's health insurance marketplace.

Even those few states that have developed provider-specific laws mostly have established standards that are similar or almost identical to the state's HMO laws. The states that have done so include Georgia, Iowa, Kentucky, New York, Oklahoma, and Texas. Where there are differences in regulation between provider-specific and non-provider-specific laws, some states tend to be leaning toward eradicating those differences. For example, the Health Systems and Plans Committee of the state of Iowa's Health Regulation Task Force recommended that differences between the provider-specific and non-provider-specific laws be eliminated. A very few states have indicated that they may not regulate health insurance organizations that assume risk under certain limited circumstances.

Consolidated Licensure Initiatives

Consistent regulatory standards according to the function of the health insuring organization rather than according to the acronym by which it is often known is the most appropriate approach to health insurance regulation in today's health insurance market. Interest in becoming a health insuring organization in the managed care market is certainly not limited to providers. Most, if not all, health insuring organizations are eager to gain a significant presence as a provider of managed care services in any given market. State insurance regulators recognize that the delivery of health services is evolving away from traditional fee-for-service insurance arrangements to managed care

arrangements of many types. Through the NAIC, states are addressing the changes which are taking place in the health insurance market. The NAIC's Regulatory Framework (B) Task Force has begun a review of NAIC model laws as part of NAIC's Consolidated Licensure of Entities Assuming Risk (CLEAR) initiative.

Through this initiative, the members of the NAIC seek to promote a more competitive marketplace by ensuring that entities that perform the same or similar functions are subject to a level regulatory playing field. CLEAR also serves to clarify that the wide array of organizations performing managed care functions, including health maintenance organizations, preferred provider organizations, point of service plans, fee-for-service plans, Blue Cross and Blue Shield plans, commercial plans, and any other plans which finance and deliver health care, fall within the scope of state regulation. The NAIC's CLEAR process will include a review of financial standards and reporting requirements as well as the incorporation of health plan accountability standards. These standards, almost all of which are completed relate to: network adequacy, quality, grievance, utilization review, provider credentialing verification, and confidentiality. Issues related to data reporting and consumer disclosure are also being explored.

Some states are reviewing their health insurance statutes with the objective of developing a

comprehensive licensure scheme. The Ohio Insurance Department has been contemplating for several years a regulatory structure that defines the business of insurance for managed care entities by focusing on how they function and not merely on how they are structured. It recently developed a Managed Care Uniform Licensure Act for Health Insuring Corporations designed to achieve this end. The bill repeals the laws which govern prepaid dental plan organizations, medical care corporations, health care corporations, dental care corporations, and health maintenance organizations, and creates one type of regulated entity called health insuring corporations (HICs). The HIC is defined broadly enough to encompass all entities that assume insurance risk. This legislation has been sponsored by State Representative Dale VanVyven and State Senator Karen Gillmor and is currently pending in the Ohio General Assembly.

Under its uniform licensure bill, all managed care plans conducting the business of insurance would be subject to minimum financial standards. The Department feels that is appropriate for the following reasons:

- Minimum standards help to ensure that funds will be available to pay consumer claims;
- Minimum standards provide purchasers of insurance with a level of security that health insuring organizations will possess the financial ability to make good on their obligations as stated in the policy or contract; and,
- Minimum standards allow health insuring organizations, and if necessary, regulators the time to take corrective action should the organization's financial condition become impaired.

At the NAIC, an important component of the CLEAR effort is the development of a Health Organizations Risk-Based Capital (HORBC) formula. The risk-based capital (RBC) approach is a formula that sets minimum capital requirements according to the level of known risk being assumed by the health insuring organization. An RBC formula acknowledges arrangements that increase and reduce risk, such as the extent to which services are directly delivered or risk is shifted through payments to subcontracting providers. An RBC formula is a marked departure from the traditional fixed level approach that states have used to establish insurer's minimum capital and surplus requirements. RBC formulas have been in use for several years in state regulation of life and health, and property and casualty, insurers.

The NAIC HORBC Working Group is now developing a prototype health RBC formula for managed care organizations. In addition to testing, debating, and reviewing the formula proposed by the American Academy of Actuaries (which provided technical assistance to the NAIC), the NAIC is also soliciting input from interested parties, trade associations (including those that represent providers), academics and health care economists. The input from all interested parties is being used by the NAIC HORBC Working Group to develop the prototype formula as a practical regulatory tool. The working group anticipates the prototype formula will be completed this

summer. As with the life and health, and property and casualty, formulas, the NAIC's HORBC formula for managed care organizations will be reassessed and refined continuously to reflect the results of ongoing evaluation and new arrangements that have developed in the marketplace.

The NAIC's CLEAR effort, as exemplified by the objectives of the Ohio bill, embodies the states' focus on regulation by function and not by acronym. All health insuring organizations engage in functions that involve a range of risks. State insurance regulation provides fundamental consumer protections for consumers and others that may be affected by the health insurance arrangement. The ownership or control of the organization does not alter to any substantive degree the extent to which that risk is present or those fundamental consumer protections are essential.

STATE INSURANCE REGULATION AND THE MEDICARE PROGRAM

State insurance regulation complements well the objectives of the Medicare program for a number of reasons. The state regulatory framework reassures the federal government that the organizations with which it contracts have met fundamental standards for engaging in insurance arrangements. It also assures the federal government that these organizations are receiving an adequate level of oversight for those functions. These fundamental standards are not limited to financial solvency

standards. State insurance regulations related to market conduct standards and financial examination activities are also essential components for effective consumer protection. Because of the activities of the states, the federal government saves considerable resources which it would otherwise have to spend in order to regulate effectively health insuring organizations.

Preemption of State Insurance Regulation

Under the current regulatory framework for Medicare, an HMO or competitive medical plan is required to obtain a state insurance license prior to serving Medicare managed care beneficiaries as a Medicare risk contractor. In most instances, the Medicare HMO is also required to serve commercial enrollees as well. However, in the 104th and 105th Congress, proposals have surfaced which would remove some of the state regulatory foundation for these plans. For example, under H.R. 475, the "Provider Sponsored Organization Act of 1997," health insuring organizations that meet the definition of "qualified provider-sponsored organization" (PSO) would not be required to meet either of these requirements in certain circumstances.

H.R. 475 defines "qualified provider-sponsored organization" as a public or private entity that is a provider or a group of affiliated providers organized to deliver a spectrum of health care services

(including basic hospital and physicians services) under contract to purchasers of such services. It does list four ways in which an organization would be considered a group of affiliated providers. The specific language of H.R. 475 makes it difficult to understand what organizations actually would be considered a qualified PSO. The bill does not define the term provider. The definition of affiliation is also loose. Further, while qualified PSOs must provide a substantial portion of services directly, the definition of substantial portion is left to be defined by the Secretary.

The definition of qualified PSO in this bill has the same problems as other federal proposals that have attempted to differentiate a provider-sponsored health insuring organization from one that is not provider-sponsored. Health insuring organizations currently licensed by the states as HMOs are not mutually exclusive from the organizations that might fall within the proposed legislation's definition of qualified PSO. Because of the lack of substantive difference among provider and non-provider health insuring organizations, the proposed definitions for PSOs cannot help but sweep in non-provider groups. Favored treatment by acronym for organizations that are not substantively different from other health insuring organizations will result in more fragmentation of the health insurance market and undermine the state regulatory process. Further, we respectfully submit that the decision of what is an organization qualified to participate in the health insurance market, whether public or private, ought to remain with the states.

The bill recognizes that these organizations are involved in health insurance activities, and would otherwise be subject to state insurance laws by requiring that they obtain a state insurance license after January 1, 2002. Yet, the bill also establishes federal standards for these organizations, including solvency standards. Until January 1, 2002, the state may not license health insuring organizations that only provide health insurance services to the Medicare managed care program and are qualified PSOs. The bill gives the Secretary of the Department of Health and Human Services (HHS) ninety (90) days to process an application for certification as a qualified PSO after receipt of a completed application. This timeframe may be significantly less than the timeframe the Secretary currently takes to process the application of a Medicare risk contractor. According to one source, it takes approximately six (6) months to obtain approval as a Medicare risk plan once a complete application has been submitted.[5]

The bill ties the states' ability to perform its responsibilities after January 1, 2002 to the adoption of specific federal requirements shifting significant responsibility away from the states. After January 1, 2002, a state may license these organizations if the state's solvency standards are identical to the federal standards and its other standards are substantially equivalent to federal standards. Further, the bill gives the Secretary of HHS the authority to waive state licensure requirements if the state does not act on the application within 90 days, or the state denies the application and the Secretary determines that the state's standards impose unreasonable barriers to market entry. The bill also requires that the Secretary of HHS contract with the appropriate state agency to monitor the qualified PSO's performance.

While the bill draws upon the NAIC's HMO model for solvency requirements, its differences from the model are significant. These differences include the requirements for minimum net worth, the factors that are required to be considered in the calculation of net worth requirements, and the statutory accounting treatment of health delivery assets. The adoption of these standards at the federal level will undermine effective solvency regulation at both the state and federal level.

In addition to providing for inadequate solvency standards, the bill also does not consider the differences in health insurance markets throughout the country. States have experienced different levels of managed care penetration, in part because of the different evolutionary stages of their health care markets. The level of managed care penetration impacts the kinds of standards that might be appropriate. Consequently, uniform regulatory standards across the country may hinder, instead of foster, the growth of managed care in the Medicare program or the commercial market. We respectfully request that this Subcommittee acknowledge the differences in heath insurance markets and recognize the expertise of the states in applying appropriate consumer protection standards for their jurisdictions.

Because, under this proposal, the states will not have the ability to perform basic underlying licensure activities, for the next few years the federal government will be exclusively responsible for enforcement of the bill's standards. Without the underlying licensure activities conducted by state insurance departments, the federal program will be burdened with an additional degree of monitoring and enforcement for these organizations. This burden may be particularly acute given the lack of experience of many providers in assuming insurance risk. The early years of a health insuring organization's development are the most critical and precarious. While the Medicare program has in place some standards and performs some oversight, the level of standards and oversight do not mirror the depth of state regulation.

Further, the Medicare program does not currently have in place the resources to duplicate the state regulatory framework

or the breadth of experience to perform effective consumer protection. Absent significant investments in a regulatory framework by the federal government, consumers will not benefit from the necessary protections offered by state insurance regulation.

CONCLUSION

For state insurance regulators, the determination of whether and how to regulate an organization is triggered by the function the organization performs and not the acronym by which the organization may be known. In making such assessments, state insurance regulators focus on whether the organization engages in the business of insurance. To this end, the most essential element to consider is whether the organization has assumed insurance risk. The acronym or ownership of an organization should not impact the decision whether an organization should be treated as a health insuring organization under the existing regulatory structure. This principle applies to organizations that are provider-sponsored. Provider-sponsored organizations assume insurance risk and ought to be regulated like other health insuring organizations by the states.

State insurance regulation offers essential elements of an effective regulatory framework for organizations serving the Medicare managed care program. We urge you not to hinder the ability of the states to use their expertise and apply the standards appropriate to their market. Federal preemption of state insurance regulation will weaken protections for Medicare beneficiaries, further

segment the health insurance market, and result in standards inappropriately tailored to some state insurance markets.

We appreciate the opportunity to testify before you today concerning the regulation of provider-sponsored organizations. The NAIC looks forward to working with the 105th Congress on this and other issues of mutual concern.

[1] 15 U.S.C. § 1011-1015.

[2] Sutton, Harry L., Jr. , F.S.A., Reinsurance in the Managed Care Environment, Society of Actuaries (1996).

[3] Specifically, the model requires that HMOs maintain a minimum net worth equal to the **greater** of $1,000,000; or two percent of annual premium revenues on the first $150,000,000 of premium and one percent of annual premium revenues in excess of $150,000,000; or an amount equal to the sum of three months uncovered health care expenditures; or an amount equal to the sum of eight percent of annual health care expenditures (except those paid on a capitated basis or managed hospital payment basis) and four percent of annual hospital expenditures paid on a managed hospital payment basis. NAIC Model Act Section 13 (model 430).

[4] Pat J. Butler, J.D., Dr. P.H. and Elizabeth Mitchell, Health Care Provider Networks: Regulatory Issues for State Policy Makers, National Academy for State Health Policy (February 1996) citing Physician Payment Review Commission 1995 Annual Report to Congress.

[5] Taylor, Roger S. and Craig Schub, *Medicare Risk Plans: The Health Plan's View*, Managed Health Care Handbook, Peter R. Kongstvedt, ed., 3d ed., 746 (Aspen 1996).